ASSEMBLY BILL No. 343

Introduced by Assembly Member Chan

February 11, 2003

An act to amend Sections 12693.32, 12693.325, 12693.326, and 12693.85 of, to add Section 12693.905 to, and to repeal Sections 12693.86, 12693.87, 12693.88, and 12693.89 of, the Insurance Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 343, as introduced, Chan. Healthy Families Program.

Existing law establishes the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health services to an eligible person. Under the program, eligibility is based upon an application submitted to the board. The board, in administering the program, may pay designated individuals or organizations an application assistance fee in specified circumstances if the individual or organization assists an applicant to complete the program application. Under the program, an applicant may appeal specified decisions, including those regarding program eligibility, to the board in accordance with a specified process. Existing law repeals the program on January 1, 2004.

This bill would specify, except as provided, that no individual or organization may solicit or receive any compensation from an applicant or subscriber for offering or providing program application assistance. The bill would make a violation of this provision subject to a civil penalty that would be deposited into the Healthy Families Fund. Because the bill would increase the amount of revenue in a continuously appropriated fund, it would make an appropriation. The bill would also

delete the existing appeal process and would, instead, specify that the appeal be conducted in accordance with either current administrative hearing procedures or a procedure adopted by the board. The bill would additionally authorize the board to establish pilot programs to develop alternative forms of financing and delivering health care services.

Vote: $^2/_3$. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 12693.32 of the Insurance Code is amended to read:

12693.32. (a) The board may pay designated individuals or organizations an application assistance fee, if the individual or organization assists an applicant to complete the program application, and the applicant is enrolled in the program as a result of the application.

(b) The board may establish the list of eligible individuals, or categories of individuals and organizations, the amount of the application assistance payment, and rules necessary to assure the integrity of the payment process.

(c) The board, as part of its community outreach and education campaign, may include community-based face-to-face initiatives to educate potentially eligible applicants about the program and to assist potential applicants in the application process. Those entities undertaking outreach efforts shall not include as part of their responsibilities the selection of a health plan and provider for the applicant. Participating plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or phone solicitation of applicants for enrollment except through employers with employees eligible to participate in the purchasing credit mechanism. However, information approved by the board on the providers and plans available to prospective subscribers in their geographic areas shall be distributed through any door-to-door activities for potentially eligible applicants and their children.

(d) (1) All assistance offered to an individual applying to the program shall be free of charge. Except as provided in subdivision (a) or by a regulation adopted by the board, no individual or organization offering or providing assistance to an applicant to

complete the program application shall solicit or receive any fee or remuneration from the applicant or subscriber for offering or providing that service.

(2) A person who violates this subdivision or a regulation adopted by the board pursuant to this subdivision, shall be assessed a civil penalty of five hundred dollars ($500) for each violation. For this purpose, a violation occurs each day a solicitation is published on an Internet Web site or is otherwise circulated to the public. This penalty is in addition to any other remedy or penalty provided by law. All penalties collected under this paragraph shall be deposited in the State Treasury to the credit of the Healthy Families Fund.

(3) An action to assess the civil penalty described in paragraph (2) shall be brought by the Attorney General at the request of the board. The action shall be filed within three years of the date the board discovered the facts indicating a violation of this subdivision.

SEC. 2. Section 12693.325 of the Insurance Code is amended to read:

12693.325. (a) (1) Notwithstanding any provision of this chapter, a participating health, dental, or vision plan that is licensed and in good standing as required by subdivision (b) of Section 12693.36 may provide application assistance directly to an applicant acting on behalf of an eligible person who telephones, writes, or contacts the plan in person at the plan's place of business, or at a community public awareness event that is open to all participating plans in the county, or at any other site approved by the board, and who requests application assistance.

(2) Until January 1, 2006, a participating health, dental, or vision plan may also provide application assistance directly to an applicant only under the following conditions:

(A) The assistance is provided upon referral from a government agency, school, or school district.

(B) The applicant has authorized the government agency, school, or school district to allow a health, dental, or vision plan to contact the applicant with additional information on enrolling in free or low-cost health care.

(C) The State Department of Health Services approves the applicant authorization form in consultation with the board.

(D) The plan may not actively solicit referrals and may not provide compensation for the referrals.

(E) If a family is already enrolled in a health plan, the plan that contacts the family cannot encourage the family to change health plans.

(F) The board amends its marketing guidelines to require that when a government agency, school, or school district requests assistance from a participating health, dental, or vision plan to provide application assistance, that all plans in the area shall be invited to participate.

(G) The plan abides by the board's marketing guidelines.

(b) A participating health, dental, or vision plan may provide application assistance to an applicant who is acting on behalf of an eligible or potentially eligible child in any of the following situations:

(1) The child is enrolled in a Medi-Cal managed care plan and the participating plan becomes aware that the child's eligibility status has or will change and that the child will no longer be eligible for Medi-Cal. In those instances, the plan shall inform the applicant of the differences in benefits and requirements between the Healthy Families Program and the Medi-Cal program.

(2) The child is enrolled in a Healthy Families Program managed care plan and the participating plan becomes aware that the child's eligibility status has changed or will change and that the child will no longer be eligible for Healthy Families. When it appears a child may be eligible for Medi-Cal benefits, the plan shall inform the applicant of the differences in benefits and requirements between the Medi-Cal program and the Healthy Families Program.

(3) The participating plan provides employer-sponsored coverage through an employer and an employee of that employer who is the parent or legal guardian of the eligible or potentially eligible child.

(4) The child and his or her family are participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.

(5) The child's family, but not the child, is participating through the participating plan in COBRA continuation coverage

or other group continuation coverage required by either state or federal law, and the group continuation coverage will expire within ~~the past~~ 60 days, or has expired within the past 60 days.

(c) A participating health, dental, or vision plan employee or other representative that provides application assistance shall complete a certified application assistant training class approved by the State Department of Health Services in consultation with the board. The employee or other representative shall in all cases inform an applicant verbally of his or her relationship with the participating health plan. In the case of an in-person contact, the employee or other representative shall provide in writing to the applicant the nature of his or her relationship with the participating health plan and obtain written acknowledgement from the applicant that the information was provided.

(d) A participating health, dental, or vision plan that provides application assistance may not do any of the following:

(1) Directly, indirectly, or through its agents, conduct door-to-door marketing or phone solicitation.

(2) Directly, indirectly, or through its agents, select a health plan or provider for a potential applicant. Instead, the plan shall inform a potential applicant of the choice of plans available within the applicant's county of residence and specifically name those plans and provide the most recent version of the program handbook.

(3) Directly, indirectly, or through its agents, conduct mail or in-person solicitation of applicants for enrollment, except as specified in subdivision (b), using materials approved by the board.

(e) A participating health, dental, or vision plan that provides application assistance pursuant to this section is not eligible for an application assistance fee otherwise available pursuant to Section 12693.32, and may not sponsor a person eligible for the program by paying his or her family contribution amounts or copayments, and may not offer applicants any inducements to enroll, including, but not limited to, gifts or monetary payments.

(f) A participating health, dental, or vision plan may assist applicants acting on behalf of subscribers who are enrolled with the participating plan in completing the program's annual eligibility review package in order to allow those applicants to retain health care coverage.

(g) Each participating health, dental, or vision plan shall submit to the board a plan for application assistance. All scripts and materials to be used during application assistance sessions shall be approved by the board and the State Department of Health Services.

(h) Each participating health, dental, or vision plan shall provide each applicant with the toll-free telephone number for the Healthy Families Program.

(i) When deemed appropriate by the board, the board may refer a participating health, dental, or vision plan to the Department of Managed Health Care or the State Department of Health Services, as applicable, for the review or investigation of its application assistance practices.

(j) The board shall evaluate the impact of the changes required by this section and shall provide a biennial report to the Legislature on or before March 1 of every other year. To prepare these reports, the State Department of Health Services, in cooperation with the board, shall code all the application packets used by a managed care plan to record the number of applications received that originated from managed care plans. The number of applications received that originated from managed care plans shall also be reported on the board's Web site. In addition, the board shall periodically survey those families assisted by plans to determine if the plans are meeting the requirements of this section, and if families are being given ample information about the choice of health, dental, or vision plans available to them.

(k) Nothing in this section shall be seen as mitigating a participating health, dental, or vision plan's responsibility to comply with all federal and state laws, including, but not limited to, Section 1320a-7b of Title 42 of the United States Code.

(*l*) Paragraph (2) of subdivision (a) shall become inoperative on January 1, 2006.

SEC. 3. Section 12693.326 of the Insurance Code is amended to read:

12693.326. Notwithstanding any other provision of this part, a new subscriber in the program shall be allowed to switch his or her choice of ~~health plan~~ *plans* once within the first three months of coverage for any reason.

SEC. 4. Section 12693.85 of the Insurance Code is amended to read:

12693.85. *(a)* Program decisions described in ~~this section~~ *subdivision (b)* may be appealed to the board. ~~If an applicant believes that a written decision on one of the following specified issues was made in violation of the program statutes or regulations, or other written representation of program policy made to the individual by the program or the board, that individual may file an appeal with the board. Decisions~~ *An applicant or subscriber shall be accorded the opportunity for an administrative hearing conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code or pursuant to a process set forth in regulations adopted by the board. The board may adopt the regulations as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For purposes of that chapter, including Section 11349.6 of the Government Code, the adoption of the regulations shall be considered by the Office of Administrative Law to be necessary for the immediate preservation of the public peace, health and safety, and general welfare.*

(b) Decisions that may be appealed are the following:

~~(a)~~

(1) A decision that ~~a child~~ *an individual* is not qualified to participate or continue to participate in the program.

~~(b)~~

(2) A decision that ~~a child~~ *an individual* is not eligible for enrollment or continuing enrollment in the program.

~~(c)~~

(3) A decision as to the effective date of coverage.

SEC. 5. Section 12693.86 of the Insurance Code is repealed.

~~12693.86. (a) An appeal shall be filed in writing with the executive director within 60 calendar days of the date of the notice of the decision being appealed.~~

~~(b) An appeal shall include all of the following:~~

~~(1) A copy of any decision being appealed, or a written statement of the action or failure to act being appealed.~~

~~(2) A statement specifically describing the issues that are disputed by the appellant.~~

~~(3) A statement specifically describing the program statute or regulation, or other written representation of program policy that the appellant believes the program or board violated.~~

~~(4) A statement of the resolution requested by the appellant.~~

~~(5) Any other relevant information the appellant wants to include.~~

~~(c) Any appeal that does not specifically allege a violation of a program statute or regulation, or other written representation of program policy will be deemed to be a request for program review pursuant to Section 12693.88.~~

~~(d) An appeal that specifically alleges a violation of program statute or regulation or other written representation of program policy, but fails to include any other necessary information, shall be returned to the appellant without review. The appellant may resubmit the appeal. The resubmittal shall be filed within the time limits of subdivision (a) or within 20 calendar days of the receipt of the returned appeal, whichever is later.~~

SEC. 6. Section 12693.87 of the Insurance Code is repealed.

~~12693.87. (a) Any appellant who files an appeal pursuant to Section 12693.85 shall receive an initial administrative review of the appeal.~~

~~(b) Administrative reviews of appeals shall be conducted in two steps. Each appeal will be reviewed by the program to determine if the requested resolution is required by the statutes and regulations governing the program, or required in order to be consistent with a written representation of program policy made by the program or the board. If so, the appropriate action will be taken within 30 days of the receipt of the appeal, and the appellant will be notified. If not, the appellant will be so notified within 30 days of the receipt of the appeal and informed that he or she may request review by the executive director. This request must be filed in writing with the executive director within 30 days of the date of the notice of the program determination and shall include the information specified in subdivision (b) of Section 12693.86.~~

~~(c) In conducting an administrative review of an appeal, the executive director may contact the appellant and any other party for further information.~~

~~(d) The executive director's decision shall be in writing.~~

~~(e) The appellant retains the right to request an administrative hearing if the appellant is not satisfied with the decision of the executive director. Such a request shall be filed within 30 calendar days of receipt of the executive director's decision. It shall include~~

~~a clear and concise statement of what action is being appealed, and the reasons the executive director's decision is not correct.~~

SEC. 7. Section 12693.88 of the Insurance Code is repealed.

~~12693.88. In addition to the appeal process established above, the board shall establish a program review process. If a subscriber or purchasing credit member is not eligible to file an appeal pursuant to Section 12693.85, but wants to have any program decision reviewed, he or she may request that the program review the decision. A review pursuant to this section is separate from and independent of an appeal pursuant to Section 12693.85, and a person that files a request pursuant to this section shall not, thereby, gain any right of appeal. Pursuant to Section 12693.49, any dissatisfaction with an action of a participating health, vision, or dental plan shall be resolved with the plan rather than by requesting program review. When an appeal that requests an administrative hearing is received, the appeal shall be set for hearing as provided in Section 12693.89.~~

SEC. 8. Section 12693.89 of the Insurance Code is repealed.

~~12693.89. (a) Administrative hearings of appeals shall be conducted according to the appeal procedures, including pre- and post-hearing procedures, set forth in Article 3 (commencing with Section 1140) of Chapter 2 of Division 2 of Title 1 of the California Code of Regulations. Article 3 (commencing with Section 1140) is hereby incorporated by reference, subject to the following modifications:~~

~~(1) Reference to the Health and Welfare Agency or the component department shall be deemed reference to the Managed Risk Medical Insurance Board.~~

~~(2) Reference to the private nonprofit human service organization shall be deemed reference to the appellant.~~

~~(3) Reference to Health and Safety Code sections providing the bases, grounds, authorization, or procedures for appeals shall be deemed reference to the bases and authorization, for appeal found in Section 12693.85 and the appeal procedures found in this section.~~

~~(4) The 30-day time period specified in subdivision (b) of Section 1140 of Title 1 of the California Code of Regulations shall be extended to 60 days, and the 10-day time period in subdivision (a) of Section 1141 of Title 1 of the California Code of Regulations shall be extended to 30 days.~~

~~(5) If the proposed decision submitted to the board is not adopted as the decision, the board may itself decide the case on the record, or may refer the case to the same hearing officer to take additional evidence. If the case is referred back to the hearing officer, the hearing officer shall prepare a new proposed decision based on the additional evidence and the record of the prior hearing.~~

~~(6) The decision of the board shall be issued within 90 days following the initial hearing or, if the case is referred back to the hearing officer, within 90 days of the second hearing.~~

~~(b) The board may elect to have a hearing conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.~~

SEC. 9. Section 12693.905 is added to the Insurance Code, to read:

12693.905. (a) In providing benefits under this part, the board may seek the development of alternative forms of financing and delivering health care services. In carrying out the intent of this part, the board may contract with providers, counties, or other organizations to establish pilot programs that demonstrate the value of alternative models of delivering or financing health care services and may implement those alternatives. In establishing a pilot program, the board may modify, to the extent permitted by federal law, the eligibility determination processes or criteria for the programs. The board shall evaluate each pilot program on an annual basis for its efficiency, effectiveness, and quality.

(b) If the board determines that it will implement a pilot program on a permanent basis, the board may extend the duration of the pilot program until its permanent implementation can be accomplished. The extension shall be for a term of less than one year. The term of the extension may be renewed for additional one-year periods if the board has completed an evaluation that includes findings supporting an extension.

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